RETURN BY 4/1/05

THE LOCAL CHOICE HEALTH BENEFITS PROGRAM
EMPLOYER RENEWAL DATA SHEET

Please complete all applicable information and return this sheet to the address shown below. You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan.

1. **Group Name**_____

2. **Effective Date: From**_____**To**_____

3. **Number of Persons Eligible/Participating**

	# Eligible Employees	# Participating Employees
Active Full Time Employees		
Active Part Time Employees		
COBRA Eligibles		
Retirees Not Eligible for Medicare		
Retirees Eligible for Medicare		

- **Your definition of Full-Time Employee:**

  _____

- **Your definition of Part-Time Employee (if covered):**

  _____

- **Are members of your Governing Body eligible?**

  ☐ Yes, as full-time ☐ Yes, as part-time ☐ No

- **Have any of your definitions changed since your last renewal?**

  ☐ Yes ☐ No

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
Phone (804) 786-6460 Fax (804) 371-0231

You must order your enrollment materials using the Materials Order form.
Fax your order to the number shown at the top of the order form.

GROUP NAME: _____

4. Benefit Plan(s) to be offered and Monthly Premium for *each* Employee/Retiree. Please check the plan names. Enter the individual premium rates from your proposal for all selected plans, not the total monthly premium for your group.

	PPO Plans				HMO Plan
	☐Key Advantage Expanded	☐Key Advantage 200	☐Key Advantage 300	☐Key Advantage 500	☐Kaiser Permanente (Northern Virginia Only)
Active					
Single	$	$	$	$	$
Employee +1	$	$	$	$	$
Family	$	$	$	$	$
Retirees Not Eligible For Medicare					
Single	$	$	$	$	$
Employee +1	$	$	$	$	$
Family	$	$	$	$	$

Retirees Eligible for Medicare			
	☐Advantage 65	☐Advantage 65 with Dental/Vision	☐Medicare Complementary
Single	$	$	$

5. List Contributions:

Minimum Employer Contribution:

Full-Time: 80% of average single cost • Part-Time: 40% of average single cost • Additional Cost of Dependent Coverage (if required): 20% of average cost

No employer contribution is required for dependents if more than 75% of all eligible employees are enrolled.

	Single Employer / Employee		Dual Employer / Employee		Family Employer / Employee	
Active Full Time (FT)	$	$	$	$	$	$
Active Part Time	$	$	$	$	$	$
Retiree without Medicare	$	$	$	$	$	$
Retiree with Medicare	$	$	$	$	$	$

6. I hereby certify that the above information is correct to renew The Local Choice Health Benefits Program.

_____/_____

Group Executive Administrator **(Signature Required)**/Date Print Name & Title

Telephone: _____/ Fax: _____

Email: _____